

# OBSTETRICAL SERVICES

## ELIGIBLE PROVIDERS

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In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the [provider enrollment chart](#) for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the [South Dakota Medicaid Provider Agreement](#).

Obstetrical services can be provided by the following enrolled providers as allowed by their scope of licensure:

- Physicians;
- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists; and
- Nurse midwives.

## ELIGIBLE RECIPIENTS

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Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's [online portal](#).

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

## COVERED SERVICES AND LIMITS

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### General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

### Initial Prenatal Visit Reporting

South Dakota Medicaid reimburses the reporting of the initial prenatal visit for pregnant recipients. Reporting should be billed to Medicaid within 15 days of the initial prenatal visit using CPT code 0500F. The code is reimbursable once per pregnancy. Providers should include any other services rendered on that date of service on the claim as usual. Providers are encouraged to report this code as it will allow Medicaid and the Department of Health to provide additional educational materials and case management services if necessary to pregnant women.

For FQHC, RHC, or IHS the code should be listed on the encounter claim and it will be reimbursed at the fee-for-service rate in addition to the encounter.

### Global Obstetrics Codes

The global obstetrics code must be billed if one practitioner or practitioners within the same group provide all components of the recipient's obstetrical care including 4 or more antepartum visits, delivery, and postpartum care. Itemization of obstetric related services may occur in the following situations:

- A recipient transfers into or out of a physician or group practice;
- A recipient is referred to another physician during her pregnancy;
- A recipient has the delivery performed by another physician or health care professional not associated with her physician or group practice;
- A recipient terminates or miscarries her pregnancy; or
- A recipient changes insurers during her pregnancy and the change prevents the billing of all of the services under the global code.

### FQHC, RHC, IHS

If a FQHC, RHC, or IHS provides the prenatal care or postpartum care to a recipient, they should itemize their billing for the service. Prenatal services should be billed using the applicable EM code and pregnancy related diagnosis code. Providers must not bill duplicative services. For example, it is not permissible to bill for prenatal services using an EM code and bill the global delivery code.

If a third-party payer requires billing the services under a different code, the provider should note that on the explanation of benefits that they submit with the claim. The claims should still be billed to Medicaid using the applicable EM code.

### Global Period

The global period starts the date of the initial visit in which the pregnancy is confirmed and extends through the end of the postpartum period (56 days after vaginal delivery and 90 days after c-section). If a global code is billed, use the date of delivery as the date of service. A provider may not submit separate claims for the antepartum care, delivery services, or postpartum care when using either of the global delivery codes. Global services should be billed for using the applicable global CPT code 59400, 59510, 59610, or 59618.

### Services Included in the Global Obstetrical Package

Per CPT guidelines and the American Congress of Obstetricians and Gynecologists (ACOG), the following services are included in the global obstetrics package:

- All routine prenatal visits until delivery;
- Initial and subsequent history and physical exams;
- Recording of weight, blood pressures, and fetal heart tones;
- Routine chemical urinalysis (CPT codes 81000 and 81002);
- Admission to the hospital including history and physical;
- Inpatient E/M service provided within 24 hours of delivery;
- Management of uncomplicated labor;
- Vaginal or cesarean section delivery (limited to a single gestation);
- Delivery of placenta (CPT code 59414);
- Administration/induction of intravenous oxytocin (CPT codes 96365-96367);
- Insertion of cervical dilator on same date as delivery (CPT code 59200);
- Repair of first or second degree lacerations;
- Simple removal of cerclage (not under anesthesia);
- Uncomplicated inpatient visits following delivery;
- Routine outpatient E/M services provided within 6 weeks of delivery;
- Postpartum care only (CPT code 59430); and
- Education services such as breastfeeding, lactation, and basic newborn care.

Per ACOG coding guidelines, reporting third or fourth-degree lacerations should be identified by appending modifier 22 to the global obstetrics code or delivery only code.

### Services Excluded from the Global Obstetrical Package

Per CPT guidelines and ACOG, the following services are excluded from the global obstetrics package and may be billed separately if medically necessary:

- Initial E/M to diagnose pregnancy if antepartum record is not initiated at this confirmatory visit. This confirmatory visit would be supported in conjunction with the use of ICD-10-CM diagnosis code Z32.01 (Encounter for pregnancy test, result positive).
- Laboratory tests (excluding routine chemical urinalysis)
- Maternal or fetal echography procedures (CPT codes 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76820, 76821, 76825, 76826, 76827 and 76828).
- Amniocentesis, any method (CPT codes 59000 or 59001)
- Amnioinfusion (CPT code 59070)

- Chorionic villus sampling (CVS) (CPT code 59015)
- Fetal contraction stress test (CPT code 59020)
- Fetal non-stress test (CPT code 59025)
- External cephalic version (CPT code 59412)
- Insertion of cervical dilator (CPT code 59200) more than 24 hours before delivery
- E/M services for management of conditions unrelated to the pregnancy (e.g., bronchitis, asthma, urinary tract infection) during antepartum or postpartum care; the diagnosis should support these services.
- Additional E/M visits for complications or high-risk monitoring resulting in greater than the typical 13 antepartum visits; per ACOG these E/M services should not be reported until after the patient delivers. Append modifier 25 to identify these visits as separately identifiable from routine antepartum visits.
- Inpatient E/M services provided more than 24 hours before delivery.
- Management of surgical problems arising during pregnancy (e.g., appendicitis, ruptured uterus, cholecystectomy).

Costs associated with Long Acting Reversible Contraceptives (LARC) are reimbursable if placed immediately after delivery or prior to discharge from the hospital. Refer to the [Family Planning](#) manual for additional guidance.

#### High Risk/Complications

A recipient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global OB CPT codes of 59400, 59510, 59610 or 59618. Submission of high risk or complication services must occur at the time of delivery, due to the need for an appropriate assessment for the number of antepartum visits at the time of delivery. Per ACOG coding guidelines, if a patient sees an obstetrician for extra visits to monitor a potential problem and no problem actually develops, the physician is not to report the additional visits; only E/M visits related to a current complication can be reported separately. South Dakota Medicaid will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

#### **Antepartum Care Only**

An initial evaluation and management (E/M) procedure code may be billed if the antepartum record is not initiated at the confirmatory visit. Antepartum care only codes should only be billed when the practitioner or practitioner of the same group will not be billing all 3 components of global obstetrics care (4 or more antepartum visits, delivery, and postpartum care). If antepartum services do not qualify to be billed in the global code, bill using the following codes:

- 3 or fewer antepartum visits performed – bill the appropriate E/M codes for the visits
- 4-6 antepartum visits – bill CPT code 59425
- 7 or more antepartum visits – bill CPT code 59426

If 4-6 antepartum visits are performed, do not bill for the initial antepartum visits using an E/M code. The initial 3 visits are included in CPT code 59425. If 7 or more antepartum visits are provided, only bill CPT code 59426. Do not bill CPT code 59425. The initial visits are included in 59426.

### **Delivery Only**

Delivery begins on the date of initial hospitalization for delivery and extends through the date in which the member is released from the hospital. Hospital care, related to the delivery, is considered part of the delivery charge and is not considered part of the postpartum care. If a c-section is performed, the reimbursement for delivery only charge includes payment for the surgical procedure as well as the post-surgical care. Use the applicable delivery only code in the CPT manual to bill for this service.

### **Antepartum Care and Delivery**

If both antepartum care and deliver are provided and postpartum care is not provided, the applicable antepartum only and delivery only CPT codes should be billed.

### **Postpartum Care Only**

Postpartum care begins after the patient is discharged from the hospital stay for delivery and extends throughout the postpartum period (56 days for vaginal delivery and 90 days for cesarean delivery). Postpartum care only must be billed using CPT code 59430.

Recipients eligible for Medicaid through the Unborn Children Prenatal Care Program (Aid Category 79) are covered for postpartum care billed for using the global delivery codes. Postpartum only services are not covered as the mother's Medicaid eligibility ends after delivery.

### **Delivery and Postpartum Care**

A provider that performs the delivery and postpartum care, but did not provide at least 4 antepartum visits must bill the appropriate delivery and postpartum care CPT code:

- Vaginal delivery including postpartum – bill CPT code 59410.
- C-section delivery including postpartum care – bill CPT code 59515.
- Vaginal birth after cesarean delivery (VBAC) including postpartum care – bill CPT 59614
- C-section after attempted VBAC including postpartum care – bill CPT code 59622

### **Multiple Deliveries**

Providers should bill using the following codes for multiple deliveries:

<b>Delivery</b>	<b>Baby</b>	<b>CPT Code</b>
Vaginal	Baby A	59400 or 59610
	Baby B	59409 or 59612 – Append Modifier 51
Both Cesarean Delivery	Baby A & Baby B	59510 or 59618 – Append Modifier 22 if the delivery was significantly more difficult due to multiple gestations. The

		medical record must contain supporting documentation.
One Vaginal Delivery and One Cesarean Delivery	Baby A	59510 or 59618
	Baby B	59409 or 59612 – Append Modifier 51

### **Physician Standby Services**

Physician standby services, CPT code 99360, is only covered when there is required prolonged physician attendance awaiting the birth of a newborn via cesarean and/or high-risk delivery. Physician standby services, 99360, is only billable under the mother. The procedure requires the physician's full-time attendance and cannot be providing care to another patient during the reporting period. Physician standby is considered a minimum of 30 minutes total duration of time on a given date. The physician standby procedure code, 99360, is to be billed in 30-minute increments (30 minutes = 1 unit) and must reflect the total duration of time the physician is in attendance, up to a maximum of 4 units (2 hours). Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of services reported. Total duration of less than 30 minutes may not be billed. Physician standby can be reported in addition to the following codes: 99440 and 99465.

Documentation must be maintained by the provider which should include; the medical necessity for the physician's immediate presence, a detailed report of the tasks performed, and the duration of the actual time spent with the patient.

### **Genetic Screenings**

Genetic testing included in the Newborn Metabolic Screening Program as mandated by the South Dakota Department of Health is covered without a prior authorization. Diagnostic testing for genetic abnormalities is a covered service only if the results will affect the treatment decisions for the individual. Noninvasive prenatal testing (CPT codes 81420 or 81507) requires a prior authorization as do many other genetic tests. Please refer to the [Laboratory and Pathology Services](#) manual for additional information.

### **Depression Screenings**

South Dakota Medicaid covers one depression screening (CPT code 96127) during the antepartum period. A maternal depression screening is covered during the postpartum period at 1, 2, 4, and 6 months when performed in conjunction with a well-child visit for an infant. Providers are encouraged to screen mothers who have a South Dakota Medicaid-eligible child under the age of 1. Providers must bill CPT code 96161 for maternal depression screening performed using a standardized screening tool. The service must be billed using the child's South Dakota Medicaid recipient ID number. Providers should refer the mother to follow-up treatment as necessary.

### **Obstetrical Ultrasound**

South Dakota Medicaid covers obstetrical ultrasounds during pregnancy when medical necessity is established for one or more of the following conditions:

- Establish date of conception

- Discrepancy in size versus fetal age
- Early diagnosis of ectopic or molar pregnancy
- Fetal Postmaturity Syndrome
- Guide for amniocentesis
- Placental localization associated with abnormal vaginal bleeding (placenta previa)
- Polyhydramnios or Oligohydramnios
- Suspected congenital anomaly
- Suspected multiple births
- Other conditions related directly to the medical diagnosis or treatment of the mother and/or fetus.

An E/M services is only separately reimbursable in addition to an obstetrical ultrasound procedure if the E/M service is separate and distinct and reported with a Modifier 25. South Dakota Medicaid will not reimburse obstetrical ultrasounds during pregnancy for any of the following reasons:

- Determining gender
- Baby pictures
- Elective

### **Pregnancy Loss**

South Dakota Medicaid covers services that may be necessary for the compassionate or palliative care of a child born in a non-viable pregnancy, as well as services related to the end of a pregnancy not resulting in live birth. Covered services include:

- Services associated with miscarriage, stillbirth, or a non-viable pregnancy, such as a molar pregnancy, ectopic pregnancy, or fetal death in utero; and
- Postpartum services including behavioral health services.

### **Prenatal Vitamins**

Prenatal vitamins are covered for pregnant women with a prescription.

### **Home Health Services**

Postpartum home health services are covered in limited circumstances. Refer to the [Home Health manual](#) for additional information.

The Bright Start Initiative is available to assist pregnant South Dakota Medicaid recipients. The Home Visitation program targets expectant mothers and is designed to help them improve their health in order to give birth to healthy babies. For referrals for service, questions or other information about this program, please call 1-800-227-3020.

### **USPSTF A and B Grade Recommendations**

Refer to the [Well-Child, Well-Adult, and Other Preventative Services](#) manual for information regarding coverage of USPSTF A and B grade recommendations.



## NON-COVERED SERVICES

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### General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

## DOCUMENTATION REQUIREMENTS

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### General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

## REIMBURSEMENT AND CLAIM INSTRUCTIONS

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### Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the [General Claim Guidance](#) manual for additional information.

### Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

South Dakota Medicaid recognizes third-party (primary) insurance often limits the codes that may be used when filing a claim. When another insurance requires a code not utilized by South Dakota Medicaid, the billing provider should bill with the EM and document on the EOB "primary insurance requires a different code" in order for the claim to be considered for payment.

### Reimbursement

A claim for physician services must be submitted at the provider's usual and customary charge.

Payment for physician services is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's [Physician Services](#) fee schedules.

Non-laboratory procedures including injections and immunization with no established fee are reimbursed at 40 percent of the provider's usual and customary charge. Laboratory procedures with no established fee are reimbursed at 60 percent of the provider's usual and customary charge.



### Modifier Codes

Modifier codes must be used if applicable. Some modifier codes increase or reduce payment. Please refer to our [Authorized Modifier](#) document for additional information.

When multiple modifiers are needed for the services being provided all percentages will be calculated in the payment. For example, if CPT code 30115 is billed at \$236.60 with a modifier 50 and a modifier 80 the following calculation will occur:  $(\$236.60 \times 150\%) \times 20\% =$  a payment amount of \$70.98.

### **Claim Instructions**

Claims for professional services including inpatient and outpatient professional services must be submitted on a CMS 1500 claim form or 837P. Detailed claim form instructions are available on our [website](#). A claim submitted for the services of a physician or other licensed practitioner must be for services provided by the physician or other licensed practitioner or an employee who is under the direct supervision of the practitioner. A claim submitted by a clinical nurse specialist, a certified nurse midwife, a nurse practitioner, or a physician assistant must contain the clinical nurse specialist's, the certified nurse midwife's, the nurse practitioner's, or the physician assistant's provider identification number and may not be submitted under the supervising physician's provider identification number.

### Modifiers

Claims must include any relevant modifying circumstance of the services or procedure by adding the applicable modifier code to the procedure code.

## **DEFINITIONS**

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1. "Clinical nurse specialist," an individual who is licensed under [SDCL 36-9-85](#) to perform the functions contained in [SDCL 36-9-87](#), or an individual licensed or certified in another state to perform those functions;
2. "Nurse anesthetist," an individual who is qualified under [SDCL 36-9-30.1](#) to perform the functions contained in [SDCL 36-9-3.1](#), or an individual licensed or certified in another state to perform those functions;
3. "Nurse midwife," an individual who is qualified under [SDCL Ch. 36-9A](#) to perform the functions contained in [SDCL 36-9A-13](#), or an individual licensed or certified in another state to perform those functions;
4. "Nurse practitioner," an individual who is qualified under [SDCL Ch. 36-9A](#) to perform the functions contained in [SDCL 36-9A-12](#), or an individual licensed or certified in another state to perform those functions;
5. "Other licensed practitioner" a physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or nurse anesthetist who is licensed by the state to provide services and is performing within their scope of practice under the provisions of [SDCL title 36](#).

6. "Physician," a person licensed as a physician in accordance with the provisions of [SDCL Ch. 36-4](#) and qualified to provide medical and other health services under this chapter, or an individual licensed or certified in another state to perform those functions;
7. "Physician assistant," an individual qualified and certified under the provisions of [SDCL Ch. 36-4A](#) to perform the functions contained in [SDCL 36-4A-26.1](#), or an individual licensed or certified in another state to perform those functions;

## REFERENCES

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- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

## QUICK ANSWERS

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- 1. Will South Dakota Medicaid cover a D & C for a woman in the Unborn Children Prenatal Care Program?**

Yes, South Dakota Medicaid will cover a medically necessary D & C if a woman miscarries while receiving coverage under the Unborn Children Prenatal Care Program.